HCP CARE COORDINATION POLICIES AND GUIDELINES

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Colorado Department of Public Health and Environment
Prevention Services Division
Center for Health Families and Communities
Children with Special Health Care Needs Unit
Health Care Program for Children with Special Needs (HCP)
4300 Cherry Creek Drive South
Denver, Colorado 80246

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Health Care Program for Children with Special Needs
Care Coordination Policies and Guidelines

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THE HEALTH CARE PROGRAM FOR CHILDREN WITH SPECIAL NEEDS
Care Coordination Policy and Guidelines

INTRODUCTION

In 1935 Congress enacted the Social Security Act. Title V of this act authorized the Maternal and Child Health Services programs. Since that time the children included in the program has changed from children with polio and orthopedic conditions to a wider range of conditions that affect a child's health and well being. In 1995 and 1998, the Maternal and Child Health Bureau (MCHB) and American Academy of Pediatrics (AAP) defined children with special health care needs as those who have or are at risk for chronic physical, developmental, or emotional condition that require health related services of a type or amount beyond those required by children or youth generally.

The Maternal and Child Health Bureau (MCHB), Title V Block Grant and State general funds provide financial support for this program based on the following legislation. **http://mchb.hrsa.gov/**

Federal Social Security Act 501(1) (A) Title V State Responsibilities

Allocated to States under the Maternal and Child Health Services block grant, "to provide and to assure mothers and children (particularly those with low income or with limited availability of health services) access to quality maternal and child health services by 1) providing direct services where needed to fill gaps; 2) develop and provide enabling (coordination of care) services that help families appropriate use of health care and resources; 3) provide population-based services needed to protect public health and assure optimal health; 4) build an infrastructure of planning, evaluation, research, and training that supports effective and efficient delivery of services to women, children , and families

Colorado Revised Statues, Title 25 Health Administration Article 1.5 Powers and Duties of the Department of Public Health

To operate and maintain a program for children with disabilities to provide and expedite provision of health care services to children who have congenital birth defects or who are the victims of burns or trauma or children who have acquired disabilities;

THE HEALTH CARE PROGRAM FOR CHILDREN WITH SPECIAL NEEDS (HCP)

The Health Care Program for Children with Special Needs (HCP) is a unique resource for families, health care providers, and communities. The program's goal is to help improve the health, development, and well being of Colorado's children, birth to 21 years of age, with special health care needs and their families. In Colorado, there are an estimated 225,000 children who have special health care needs (CSHCN) who may receive services.

HCP works with families, health care providers, communities, and policy makers to strengthen Colorado's capacity to meet the needs of CSHCN and their families. Through seventeen Regional Offices located within existing public health agencies across the state, efforts are made to assure local community-based health services. Through these offices public health staff supports children, youth, their families and the providers who serve them, by developing an organized, easy to use system of services and supports. They also provide population based services such as vision, hearing, and developmental screening services for children, and assisting family's access primary care and specialty health care providers and resources through HCP Health Care Coordination.
http://www.cdphe.state.co.us/ps/hcp/index.html

Strategies to Support CSHCN and Their Families

The Colorado Medical Home Initiative (CMHI) has affected the direction of HCP in recent years. The CMHI "vision" is two-fold: 1) All pediatric practitioners will provide a family-centered medical home approach which includes both PCP care coordination and access to community-based care coordination, especially for children with special health care needs (CSHCN) and 2) A medical home system will be developed to support practitioners and to address systemic barriers to a comprehensive, coordinated, medical home team approach for all children. As a result HCP has identified two primary strategies to achieve this vision.

Strategy #1: Provide Care Coordination

Care coordination is an important component of a Medical Home Team Approach. Primary care providers are encouraged to utilize HCP by requesting HCP care coordination or specialty clinic services. In addition care coordination services may be requested directly by families, local community agencies, or regional medical centers such as The Children's Hospital. Local health agencies and regional offices provide care coordination based on their local capacity and target population determined through their community needs assessment. HCP Specialty Clinic Coordination to facilitate a child or youth's access to specialty care is also considered an important element of HCP Care Coordination. **http://www.coloradomedicalhome.com/**

Strategy #2: Collaborate with Community Partners for Easy to Use Services

Families with CSHCN need services to be organized so they can use services easily. By collaborating with community partners, HCP can assess the access and organization of community services for families. Involving the HCP Family Coordinator and/or community Family Leaders is critical with these collaborative efforts. Contacting primary care providers (PCP) to inform, educate, assist, and engage them with HCP and community resources has been shown to improve care for CSHCN and their families. By engaging multiple partners in this effort across different sectors of the community, resources and solutions can be identified to improve community services for families with CSHCN. HCP CSHCN health consultation with community partners and the HCP Specialty Clinic outreach and evaluation are considered an important element of HCP systems building efforts.

CARE COORDINATION BACKGROUND

There are approximately 9.4 million -- or 12.8% of all children in the United States under the age of 18 – that have special health care needs (HRSA, 2004). Meeting the complex needs of children and youth with special health care needs (CYSHCN) and their families often requires special assistance described as care coordination. Children and youth with special health care needs require access to treatment and special services that take into account their overall growth and development. At times, the challenge for families is in accessing these services in an often-fragmented system of care (AMCHP, 2002). Care coordination helps families identify and enroll in programs and services and promotes efficiency by increasing access to care and eliminating duplication of services (AMCHP, 2003).

Care Coordination Definitions

Care coordination definitions vary among different perspectives. Two are presented here to demonstrate commonalities and differences.

Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs to achieve optimal health. (Antonelli, McAllister,& Popp, 2009)

Care Coordination Competencies	Care Coordination Functions
1. Develops partnerships	1. Provides separate visits and care coordination interactions
2. Communicates proficiently	2. Manages continuous communications
3. Uses assessments for intervention	3. Completes/analyzes assessments
4. Is facile in care planning skills	4. Develops care plans with families
5. Integrates all resource knowledge	5. Manages/tracks tests, referrals, and outcomes
6. Possesses goal/outcome orientation	6. Coaches patients/families
7. Takes an adaptable and flexible approach	7. Integrates critical care information
8. Desires continuous learning	8. Supports/facilitates care transitions
9. Applies team-building skills	9. Facilitates team meetings
10. Is adept with information technology	10. Uses health information technology

. (Antonelli, McAllister, Popp, 2009)

A client-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which:

- a client's needs and preferences are assessed
- a comprehensive care plan is developed
- services are managed and monitored by an identified care coordinator following evidence-based standards of care.

Care coordination" encompasses both health care and social support interventions across the range of settings from the home to ambulatory care to the hospital and post-acute care

HCPF Colorado Accountable Care Collaborative, Request for Information, July 2009

Differentiating Between Community Based and Primary Care Practice Care Coordination

Care coordination is used in many different ways. Generally it refers to the coordination of resources and services for families to optimize the health and well being of their children. When evaluating the goals and outcomes of care coordination it is important to clarify the perspective that is being used.

- ***Primary Care Practice Care Coordination***:

  Primary Care Coordination is based in a medical practice as the services provided to assist families with obtaining medical and specialty care, making appointments, obtaining referrals, dealing with insurance issues and linking with resources. The goal is to reduce utilization of high-cost medical care by preventing unnecessary hospitalizations or emergency room visits.

- ***Community Based Care Coordination***:

  Community Based Care Coordination helps families and youth access and manage a wide array of services and needs as determined by the family or youth. The goal is to help families as well as youth learn to effectively navigate the healthcare system, thus giving them the information and skills communicate more effectively with clinicians and deal with insurance issues. (Adapted from Snow, J., 2005)

Why is Care Coordination Needed?

National data on children with special health care needs in Colorado demonstrates the significance and need for care coordination assistance for families with CSHCN. Of the 225,000 children in Colorado with special health care needs, 12.5% of all children, approximately 24.4 % of these children have conditions that affect their daily activities and 14.3% miss more than 11 days of school due to illnesses. Additional data for Colorado include the following:

- 48.2% of CSHCN do receive coordinated, ongoing, comprehensive care within a medical home compared with 47.1% nationally.
- 20.0% of CSHCN have unmet needs for specific health care services compared with 16.1% nationally.
- 24.9% of CSHCN need referrals and have difficulty getting it compared with 21.1% nationally.
- 8.4% of CSHCN families spend 11 hours or more coordinating care of their child compared with 9.7% nationally.

- 34.6% of CSHCN have inadequate insurance compared with 33.1% nationally.
- 12.7% of CSHCN are without insurance at some point in the past year compared with 8.8% nationally.
- 20.6% of CSHCN have conditions that cause family members to cut back or stop working compared with 23.8% nationally.
- 23.9% CSHCN have conditions that cause financial problems for the family compared with 18.1% nationally.
- 27.7% of CSHCN families pay over $1,000 or more out of pocket in medical expenses per year compared with 20.0% nationally.

(2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.)

Families with children with special health care needs must take more time off work for medical appointments, therapy appointments, and attending school IEP meetings. They struggle to locate adult health providers who will care for their youth when they become 18 years of age. They spend more out of pocket money for co-pays for medical and therapy appointments. They are often required to coordinate the care of their child because no one else in the health care system has the time, desire, or knowledge to do so. (2005/2006 National Survey of Children with Special Health Care Needs, Data Resource Center for Child and Adolescent Health website.)

Although primary care providers are expected to provide coordination of care for families through a medical home approach, the reality is that the time for this is not reimbursed and primary care providers most often lack the knowledge about community resources to provide families with the information they need (2008, Colorado Medical Home Provider-Practice Management Survey). The result is that families either coordinate their child's care or a child's health care is fragmented, unorganized, and results in increased family stress and frustration, delays in seeking care, and complaints that the family is non-compliant or neglectful. Further results of lack of coordination of care include increased ER visits, increased and greater length of stay hospitalizations, lack of preventive services such as immunizations and developmental screenings with appropriate and timely referrals to early intervention services. (Antonelli, 2004; California Health Care Foundation, 2007; McAllister, et.al. 2007; Palfrey, 2004)

MCHB Goals of Care Coordination

The Association of Maternal and Child Health Programs (AMCHP 2000; 2002) outlines specific goals of care coordination including recommendations, roles and training of care coordinators, as well as research and evaluation issues.

Care coordination is considered a standard of care for children and youth with special health care needs due to the following:

- The need to plan beyond the medical needs of the child (social, developmental, educational, vocational, and financial).
- The complexity of the service system with its different entry points and eligibility criteria.
- The importance of the family's role in the center of care coordination; families are the most knowledgeable about their child's condition and they become effective leaders and partners in the care coordination process as their skills and strengths are supported, and their opinions valued and respected (AAP, 1999).
- Children and their families benefit from understanding their options of services and resources that meet their unique needs.
- Partnerships with families among providers, agencies, programs, specialists, and primary care providers are essential to effective care that truly serves families.

Goals for care coordination are described as follows:

- Improve and sustaining the quality of life for the family and the child.
- Assure access to optimal care.
- Improve systems of care for children with special health care needs

How Do Families Benefit From Care Coordination?

Public and private agencies involved in human services have historically helped families determine their needs and gain access to services (AAP, 1999). Beginning in the early 20th century, community service coordination began and evolved into the concept of "case management," which appeared in the early 1970s. In the 1980s, commercial insurers used case managers as a way to coordinate care and manage costs in "catastrophic cases" (AMCHP, 2000). Today comprehensive "care coordination" enables people to navigate through complex systems (Rosenbach and Young, 2000).

Proponents of the medical home or health care home as well as insurance providers have recognized the benefits of care coordination and case management for at risk populations. Case management often is associated with HMO's and their efforts in cost containment. The health care home and medical home recognize care coordination as an essential element of quality health care, especially for children with special needs. Outcomes for medical home care coordination include:

- Functional: decreased stress worry, school absence, increased diagnosis and treatment access, and increased family care giving competence.
- Clinical: increased preventive services for CSHCN, decreased episodes of illness, decreased acute encounters.
- Satisfaction: increased communication, office responsiveness, and care plan/continuity, family involvement.
- Cost: decreased ER visits, hospital visits, unnecessary specialty and office visits, lost parental work time, increased care coordination activities received.

(Center for Medical Home Improvement, Outcomes 2001)

o ***Case Management vs. Care Coordination***

Historically, case management programs rely on a medical model focused on the patient's health care needs only, while care coordination programs tend to use a broader social service model that considers the patient within a psychosocial context as well. Case managers tend to coordinate services within a single managed care plan, and focus only on covered services. In contrast, care coordinators may work with a full range of health and social support services offered within and outside the managed care plan, therefore often arranging both covered and non-covered services (Rosenbach and Young, 2000).

o ***Part C Early Childhood Connections Service Coordination***

Part C Early Intervention Colorado provides service coordination for children birth to 3 years of age. A service coordinator is a person who works with families during the child's involvement with Colorado's early intervention system and to help protect a family's legal rights. Federal and state laws require that all children and families served by the early intervention system have a service coordinator. A service coordinator is the families main contact and is assigned to each infant or toddler and their family within three business days of the referral being received.

Service Coordinators:

- Help families identify their strengths and needs, find resources, think about decisions the family needs to coordination all the services being received
- Assure that the rights of the child and family are protected

(Early Intervention Colorado, 2009).
http://www.eicolorado.org

o ***Health Care Policy and Finance (HCPF) Healthy Communities Outreach Workers – (EPSDT)***

The Department of Health Care Policy and Finance Provides support for clients who are eligible but not enrolled in Medicaid and clients already enrolled in Medicaid and CHP+. This model, called Healthy Communities, combines the best aspects of the EPSDT Outreach and Administrative Case Management Program and the CHP+ regional outreach program.

HCPF, At a Glance. Health Care Policy and Financing Updates. June 10, 2009.
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218622604254

o ***Family Navigator***

Family to family assistance in resolving problems with a health insurance plans, communicating with a service provider, navigating Medicaid or other public systems, and in receiving individual health insurance counseling (such as in a benefits decision and help with the appeals process). Colorado Family Voices **http://www.familyvoicesco.org/**

Essential Care Coordination Activities

MCHB has provided a description of the essential care coordination activities to include:

- **Partnering with Families** – to connect with community resources and parent support.
- **Relationship Building** – Identify and support family strengths, culture and values.
- **Assessment** –Collect and review medical and educational information, and family input to identify strengths, needs and available resources
- **Planning** – Assist the family to develop a care coordination plan with specific objectives, goals and actions to meet identified needs.
- **Implementation –** Initiate and facilitate specific activities and interventions that lead to accomplishing the goals set forth in the care plan.
- **Monitoring and Evaluation –** Gather information about the care plan's activities, interventions, and services to determine the plan's effectiveness in reaching desired goals and outcomes, and modify the plan as needed. Look at the overall effectiveness of the care coordination plan to achieve positive outcomes for families and improve the system of care for CYSHCN.

Evidence regarding care coordination outcomes and the direct benefits to the lives of individuals and children with special needs and their families continue to need evaluation. An increasing number of studies have been completed but are inconclusive due to the variability in sample sizes, study designs, and study outcome evaluations. However, it is clear that professionals in the health care field and those that work closely with children and youth with special health care needs feel strongly about the impact that care coordination has on improving the child's well being and making the lives of family members easier as well (Antonneli, et.al., 2004; McAllister, 2009; Barrett, 2000; Grupta, 2004; Jablonski, 2003).

These benefits include:

- Ongoing health promotion and disease prevention consultation
- Appropriate utilization of community resources; integration of their family within the community.
- Supportive and enjoyable family-child relationship
- Accessible and safe home environment
- Appropriate and accessible family health care.
- Understanding of medical conditions, treatments, and medications
- Reduced ER visits and avoidable hospitalizations
- Active participation in child's Individual Family Service Plan (IFSP) and Individual Education Plan (IEP)

HCP CARE COORDINATION

HCP Care Coordination is intended to improve the quality of life for CSHCN and their families by increasing a family's knowledge and ability to appropriately and effectively utilize health and community services through a *medical home team approach*, thus also decreasing health care expenditures.

HCP Care Coordination is the facilitation of access to and coordination of health (physical, mental, and dental) and social support services for CSHCN across different providers and organizations. HCP Care Coordination serves children and youth, birth to 21 years of age in all counties of Colorado. HCP Care Coordination focuses on supporting a family's participation in health care decisions, communication with health care providers, and coordinating health and community services resulting in a families increased knowledge and appropriate utilization of health care resources.

HCP Care Coordinators and the HCP Care Coordination Team

HCP Care Coordinators are public health and social workers who bring their medical and professional training and experience to address the myriad health needs of children and youth with special health care needs. They are experienced in working with other HCP Team Members including other social workers and nurses as well as dietitians, speech-language pathologists, audiologist, family coordinators, and occupational or physical therapists on behalf of families. Family coordinators as well as other members of the HCP team support and assist with the coordination of care for individual children and families as well as the coordination of services with other systems and organizations. HCP Care Coordinators also utilize the expertise of other community disciplines such as the child's primary care provider, pediatric specialists, school nurses, psychologists, early intervention service coordinators, EPSDT Outreach Workers, and others who the family indicates are members of their *Health Care Team.*

The HCP Care Coordinator is responsible for completing a care coordination assessment and identifying strengths as well as unmet needs. They partner with families in the development of a plan of care for their child or youth and based on the Care Coordination Assessment. The HCP Care Coordinator works with the family and/or youth to identify the family/youth goals they hope to achieve, the interventions to meet these goals, and determine what HCP Team Members may be most appropriate to work on different aspects of the child or youths care coordination plan. HCP Care Coordinators also utilize the expertise and consultation of other community discipline resources based on the needs of the family through individual consultation with other disciplines and by holding care conferences, including family members.

Through programs such as Colorado Responds to Children with Special Needs (CRCSN), the Colorado Birth Defects Registry, families of children with special health care needs are contacted to determine their needs and to inform them of local health and community resources. When a family has a question or concern, members of the HCP Team are available to assist them. HCP Care Coordinators assist the family in locating services such as public health services, public insurance programs, early intervention programs, housing, clothing, transportation, quality childcare, prenatal services, WIC programs, immunization clinics, and specialty care providers. Many families need little more than a phone number or address and they are able to navigate the available services. Many more families, especially those in crisis, need assistance prioritizing the steps to take first when faced with multiple needs such as accessing both housing resources and emergency health care.

The HCP Care Coordinators also provide assistance to PCPs to provide a medical home team approach, especially for CSHCN. Examples of this assistance include: providing access to and coordination of primary and specialty care through the HCP rural specialty clinics; helping PCPs to identify community and state resources; and helping families navigate and understand the health care system.

HCP Care Coordination Leads to Identification of Health Services Gaps and Needed Systems Building

HCP Care Coordinators also collaborate with community organizations and agencies to organize services in order to avoid duplication and to identify gaps that prohibit a medical home approach for CSHCN. All too often, available local community or state agencies do not meet a family's needs. When an HCP Care Coordinator identifies the unmet needs of a single family or many families, they are able to mobilize community partners to resolve these unmet needs. Examples include seeking donations for a family in need of specialized formula for their child or assistance in paying for a special medication. Other examples include seeking grant funding to develop Respite Centers so that families who otherwise have no one to watch over their child with special health care needs while they do something as simple as go to a movie. (2004, 2005, 2006, MCH HCP Operational Plan Reports)

HCP Levels of Care Coordination

HCP has defined three levels of care coordination to describe care coordination resource allocations, capacity, and costs associated with state and federal funds. The three levels of care coordination also allow a description of the families receiving different levels of HCP services. HCP care coordination interventions include the referrals, education, and services provided to families.

Level 1 Health Care Coordination:

Intake and resource information provided to families about HCP, local community health care services (public, primary care, and specialty care) and community-based services.

- **Key Elements:**
  - Identification of:
    1) Parent concerns/unmet needs
    2) Child's condition/diagnosis and age
  - Completion of the *HCP Intake Interview* to determine the families access to:
    1. A usual source of well and sick care other than the ER
    2. A consistent primary care provider (PCP) for their child/youth
    3. To private or public health insurance or a source of payment for health care
    4. To needed specialty providers
    5. T local community and family support systems
  - Provision of referrals to community support services
  - Determination of the family's need for and desire for HCP Care Coordination Services
  - Contacts with families may be made through letters, phone calls, or e-mail.

Level 2 Health Care Coordination:

Assistance provided to families in accessing health care and community-based services.

- **Key Elements:**
  - Development of a care coordination plan that identifies:
    1. Family strengths and unmet needs based on the family's concerns and questions and the *HCP Care Coordination Assessment and Planning Guide*
    2. Family goals to resolve their unmet needs.
    3. Interventions (referrals, education, and services) needed to achieve the family goals.
  - Notification to the child/youth's primary care provider about HCP involvement, care coordination progress, and the end of care coordination services. (Request for HCP Services*)*
  - Follow up to determine whether the interventions (referrals, education, and services) have been completed or acquired and whether further care coordination is needed.
  - Contacts with families may be made through phone calls, e-mail, home visits, clinic visits, and office visits.

Level 3 Health Care Coordination:

Assistance provided to families to access health care and community services in collaboration with the family, primary care provider, and/or other members of the child or youth's health care team the family and care coordinator identify.

- ***Key Elements:***
  - Based on local office capacity, local community funding, and/or contracts to reimburse services.
  - Level 3 Care Coordination Includes:
    - Development of a Care Coordination Plan based on:
      - Identification of the family's unmet needs and potential unmet needs based on the family's concerns and questions and the *HCP Care Coordination Assessment and Planning Guide*
      - Identification of the family's goals to resolve their unmet needs.
      - Identification of the interventions (referrals, education, and services) needed to achieve the family goals.
    - Notice to the child/youth's primary care provider about HCP involvement, care coordination progress, and at the end of care coordination services. (Request for HCP Services)
    - Level 3 Care Coordination Service appropriate to family (e.g.):
      - Assist youth, 14 years of age or older and their family with a Health Transition Plan
      - Assist families with an Emergency Medical Plan
      - Assist families obtain TBI Purchased Services
      - Assist families in increasing their appropriate utilization of health care services.
    - Follow up to determine whether the interventions (referrals, education, and services) have been completed or acquired and whether further care coordination is needed.
  - Contacts with families may be made through phone calls, e-mail, home visits, clinic visits, and office visits.

Examples of HCP Health Care Coordination

Level I HCP Care Coordination:

- A family requesting assistance in obtaining food and clothing was referred by the HCP social worker to local agencies that assist families needing food and clothing. She also referred the family to LEAP (for energy assistance) and low-income housing. *No further follow up was needed.*
- A family contacted HCP with questions concerning cleft lip and palate. They were considering adopting a child with this condition and needed more information before making this decision. The HCP care coordinator provided the family with contact information for the Cleft Palate Foundation as well as inform them about local resources. *No further follow up was requested.*

Level 2 HCP Care Coordination

- A teenager with questionable seizure activity and an immediate need for oral surgery contacted an HCP office. This individual did not have insurance and was not living at home. The HCP team provided consultation with the teenager and his parent that resulted in referrals to the Medicaid program for children (EPSDT), the Colorado Indigent Care Program (CICP), a primary care physician, and a local public health nurse. Follow up was provided until the family was appropriately connected to these resources.
- A family with a child with a speech delay due to a medical condition requested assistance because their request for speech therapy was denied by a public insurance plan. The word "delay" was included in the medical diagnosis and this had automatically caused a denial for authorization in the insurance system. The mother contacted the HCP staff requesting information about other possible resources to help continue the therapy while she proceeded through the appeal system. The HCP nurse encouraged the mother to continue

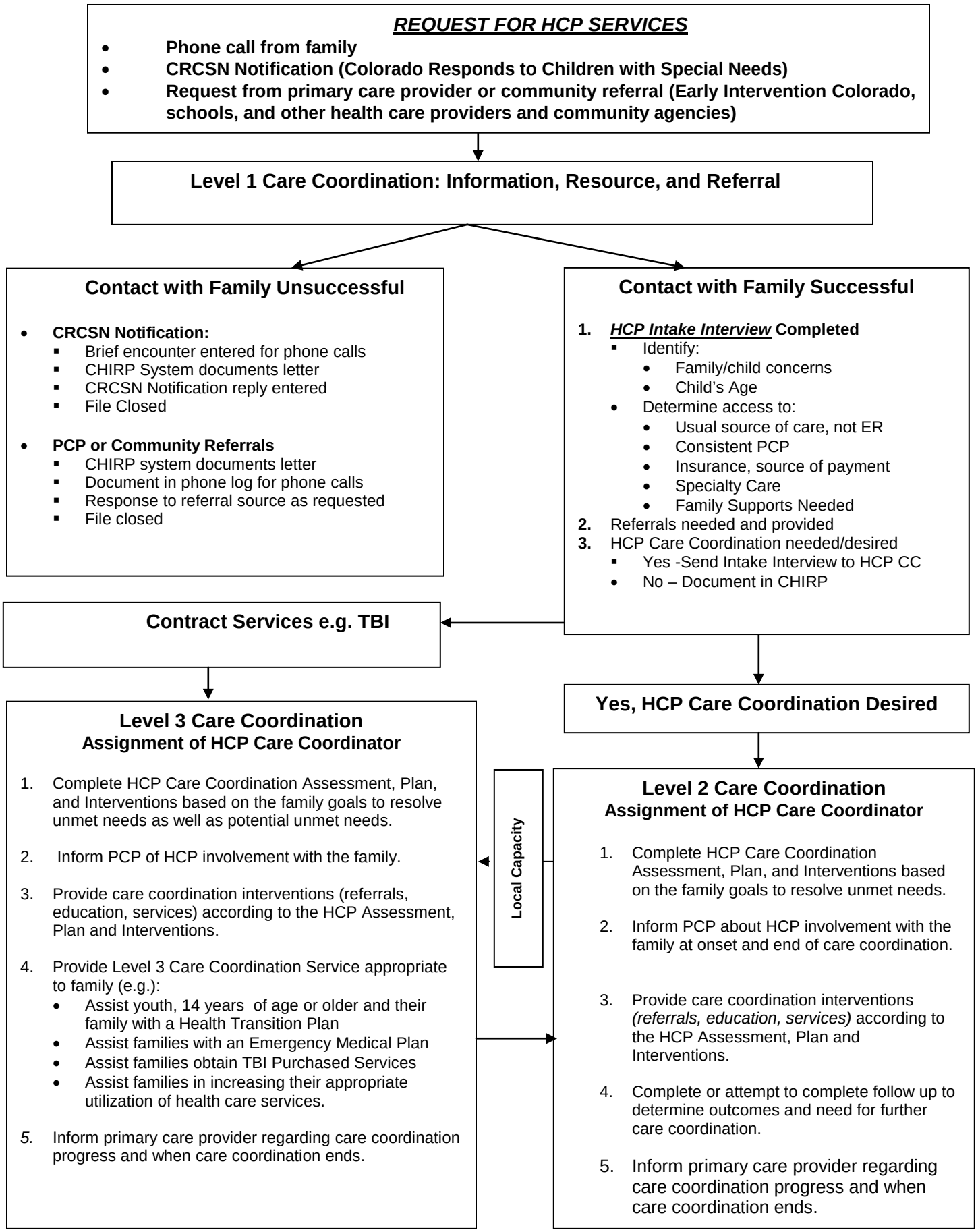
with the appeal and to talk with the school speech therapist to see what could be done at school. The mother stated that the school speech therapist told her she does not know how to deal with the child's specific problem. The HCP Speech/Language team member contacted the school therapist and offered the guidance and technical assistance the she needed to provide supportive services to the child until private therapy sessions could resume. *Once the family was connected with the appropriate community resources the family was discharged from HCP Care Coordination.*

Level 3 HCP Care Coordination

- A family had a son diagnosed with Duchenne's muscular dystrophy. Over the winter, his muscle strength began to deteriorate rapidly. In November he had been able to manage his own self-care; however, by May, he was completely dependent on his mother for assistance with all activities of daily living. The HCP care coordinator helped the family obtain an appointment with a pediatric orthopedic specialist. A referral was made to obtain a power wheelchair and an evaluation of the family's home was completed for possible renovation to allow for the installation of a lift system. The child developed cardiac problems, requiring numerous visits to the PCP and several hospitalizations. The HCP care coordinator helped arrange for homebound education when the youth became too weak to attend school. The family became socially isolated because they only had a car for transportation, which was not capable of transporting the child's power wheelchair. Discussions with the Muscular Dystrophy Association resulted in the donation of a van from another family. The HCP care coordinator and the HCP social worker accompanied the family when they received the van, providing interpretation services and emotional support to both families. As the young man's health status continued to deteriorate, hospice services were set up with the help of the HCP Care Coordinator. The HCP Social Worker contacted the family's church and arranged for additional support services. The HCP social worker provided support to the entire family in numerous ways – food bank referrals, transportation arrangements, and emotional support in dealing with the situation. The HCP nurse and social worker worked with the older brother who was missing school and at risk for associating with gangs. The younger sister received emotional support as well as she experienced her brother's deteriorating condition. *HCP Care Coordination continued for over a year in order to provide continued support, education, and resources for the family.*

- A family contacted the HCP office because their 18-month-old child had multiple medical problems and they wanted to know what services were available to help their child. The HCP Care Coordinator provided consultation to the family and linked them with a consistent primary care provider, Early Intervention Colorado, their Medicaid EPSDT Outreach Worker, and a nutritionist. The HCP Care Coordinator also assisted them in working with their PCP to obtain referrals for the child to be seen in HCP Orthopedic and Neurology clinics. HCP Care Coordination continued to provide consultation to the early intervention team regarding the health and medical implications related to the child's IFSP. *HCP Care Coordination monitoring resumed when the child reached 3 years of age and was no longer eligible for Early Intervention Colorado.*

HCP Care Coordination Model



HCP Care Coordination Minimum Standards
Under Development – See CHIRP Documentation
May 1, 2010 - September 30, 2010

HCP CARE COORDINATION OUTCOMES

The National Survey of Children with Special Health Care Needs 2005-2006 provides data for Care Coordination measures. This survey indicates the following data for Colorado's population of CSHCN:

- 93.5 % of CSHCN have a personal doctor or nurse, compared with 93.5 % nationally.
- 94.3 % of CSHCN have a usual source of care that is not the ER (sick and well care), compared with 94.3 % nationally.
- 12.7 % of CSHCN were without insurance at some point in the past year, compared with 8.8 % nationally.
- 53.7 % of CSHCN needed specialty care, compared with 51.8 % nationally.
- 5.0% of CSHCN have unmet needs for family support services, compared with 4.9% nationally.

HCP 1 Year Short Term Outcomes:

As a result of HCP Care Coordination, CSHCN will have a reduction in unmet needs and have:

1) A usual source of sick and well care, other than the ER
2) A consistent PCP (physician, nurse practitioner, or physician assistant)
3) Health insurance
4) Access to needed specialty care
5) Access to needed family support services
6) Be satisfied with HCP Care Coordination services

HCP 3 – 5 Years Mid-Term Outcomes

1) Increase in family's efficacy to appropriately manage their child's healthcare
2) Appropriate health care utilization (usual source of care)
3) Family satisfaction with medical care received
4) Improved capacity for program evaluation

HCP Long Term Outcomes

1) Improved quality of life for families and children
2) Decrease in health care expenditures
3) Evidence based understanding of the impacts of program factors on effectiveness of care coordination

HCP Care Coordination Priority Outcomes and Demographics

The *HCP Care Coordination Outcome Priorities and Demographics* identify potential factors that may impact care coordination outcomes and the complexity, acuity, and intensity of HCP Care Coordination services. HCP Care Coordination data will be described and analyzed in relationship to these factors.

- Acuity – number of unmet needs a child/youth has
- Complexity – number and/or type of conditions or diagnosis a child/youth has
- Intensity – care coordination time involved to address the child/youth's unmet needs

HCP Care Coordination Priority Data And Demographics	HCP CHIRP Screens		
	Intake and Discharge Screen	Patient & Family Screen	Other CHIRP Screens
HCP CARE COORDINATION PRIORITY OUTCOMES			
▪ **Usual source of care other than ER**	**X**		
▪ **Access to consistent to PCP: MD, NP, or PA**	**X**		
▪ **Access to specialty care**	**X**		
▪ **Available insurance**	**X**		
▪ **Family support services**	**X**		
▪ **Desire for HCP CC or to Continue HCP CC**	**X**		
▪ **Already receiving care coordination services**	**X**		
PRIORITY DEMOGRAPHICS:			
▪ **Child age**		**X**	
▪ **Child gender**		**X**	
▪ **Child ethnicity**		**X**	
▪ **Child race**		**X**	
▪ **Mother's birthday – age**		**X**	
▪ **Number of adults and children in home**		**X**	
Child/Youth/s Primary Care Provider			**Provider Screen**
Child/Youth's Health Insurance			**Insurance Screen**

HCP Care Coordination Risk Factors
CHIRP Documentation

HCP CARE COORDINATION RISK FACTORS	HCP Care Coordination Forms and CHIRP Screens	
	Assessment and Planning Guide	CHIRP Risk Factors
Child/Youth Health		
• Complex medical diagnosis or No diagnosis	X	X
• High risk pregnancy	X	X
• **Premature birth or Birth Defect**	X	X
• **Immunization not up to date**	X	X
• **Frequent ER Visits, Hospitalizations**	X	X
• **Lack of Emergency plan for medical needs**	X	X
Child/Youth Development		
• **Lack of development screening**	X	X
• **Developmental delay/disability**	X	X
• **Lack of self care or daily routines**	X	X
• **Lack of sleep/wake routines and activity**	X	X
• **Lack of transition plan to adult provider when needed**	X	X
Family Status		
▪ **Family primary care source**	X	X
• **Single parent**	X	X
• **Teen parent/s**	X	X
• **Foster care, grandparent care**	X	X
• **Parent child relationship**	x	x
• **Lack of planning, prioritizing skills**	X	X
• **Lack of decision making, coping strategies**	X	X
• **Geographic isolation**	X	X
• **Parent support systems – lack of extended family**	*X*	*X*
• **Parent education (< high school)**	X	X
▪ **Language barrier**	X	X
Psychosocial Status		
• **Mental health diagnosis**	X	X
• **Depression or post-partum depression**	X	X
• **Substance abuse**	*X*	*X*
▪ **Past abuse or neglect**	X	X
Basic Needs		
• **Homelessness**	*X*	*X*
• **Transportation**	*X*	*X*
• **Low SES, below 200% poverty**	X	X
• **Lack of insurance:**	X	X
Community Supports		
• **Lack of appropriate local supports**	X	X

HCP CARE COORDINATION QUALITY ASSURANCE
Monitoring and Evaluation

HCP monitors its care coordination program services through various systems that include, but are not limited to:

- Written HCP Care Coordination Policies and Guidelines, review of the literature, best practices, as well as evidenced based practice when available
- Family satisfaction surveys
- Systematic family participation in policy and program decisions at both the regional and state levels
- Impact of ongoing training and education of HCP care coordinators
- Quarterly and annual audit review of HCP Care Coordination Standards and Outcomes
- Quality improvement strategies based on established Care Coordination Standards of Practice as well as Care Coordination Outcomes
- See HCP Care Coordination Training Audit

HCP CARE COORDINATION RESOURCE DOCUMENTS/FORMS

Purpose of the HCP Care Coordination Forms

- Ensure consistent data entry
- Ensure effective, quality HCP Care Coordination

The information on the forms is intended to include the required data that will be used to evaluate HCP Care Coordination. The forms may be modified to meet local county health agency needs. They are also intended to facilitate consistency among the HCP Regional Offices and local county health agencies.

HCP Intake Interview (A)

Purpose: Identify status of the five (5) HCP Outcome questions and the need for HCP Services (HCP Care Coordination and Specialty Clinics)

CHIRP Documentation:

- May 1, 2010 – September 30, 2010: Required
  - Patient Screen: Child name and birth date
  - Provider Screen: Primary care provider
  - Insurance Screen: Insurance

- October 1, 2010: HCP Intake Screen Will Be Required
  - Intake Screen (New CHIRP):

Request for HCP Services (B)

Purpose: To identify the source of ***Requests for HCP Services*** and provide a tool to report back to the referral source.

CHIRP Documentation:

- May 1, 2010 – September 30, 2010: Requirement - NONE
  - Recommend – document of source of request for services in the CHIRP Communication Screen

- October 1, 2010: Will Be Required
  - HCP Intake Screen (New CHIRP)

HCP Family Information Questionnaire (C)

Purpose: to collect child/family information including family members, address, contact numbers, and demographic data (esp. ethnicity and race and mother's age and education)

CHIRP Documentation:

- May 1, 2010 – September 30, 2010: Requirement - NONE

- October 1, 2010: Additional Data Will Be Required

HCP Care Coordination Assessment and Planning Guide (D)

Purpose:

- To provide standardization for an initial HCP Care Coordination assessment of a family/child's unmet needs as well as follow up
- To identify family strengths and potential unmet needs
- To provide strategies in developing a family's care coordination plan
- To identify interventions and outcomes in meeting a family's unmet needs

CHIRP Documentation Requirement:

- May 1, 2010 – September 30, 2010: Requirement – NONE
  - Concern List – Recommended
    - Use the 6 Assessment Domains instead of the Concern List
  - Communication Screen - Recommended
    - Follow the (E) HCP Care Coordination Assessment and Planning Guide Template Outline
    - Continue to document phone calls, letter, etc.
    - Continue to document attendance at HCP Specialty Clinic only, not Clinic Visit Notes or dictated notes
  - October 1, 2010: Will Be Required for Level 2 and Level 3
    - CHIRP Assessment and Plan Screens
  - NOTE: HCP Care Coordination Assessment and Plan Documentation in CHIRP
    - Refer to June 18, 2010 HCP CHIRP Operations: Please refer to Kathy Watters Memo Link: www.hcpcolorado.org Care Coordination

HCP Care Coordination Assessment and Plan Outline (E)

Purpose: **To provide an example of an assessment and plan that might be documented in CHIRP**

HCP Care Coordination Consent and Release Template (F)

The HCP Care Coordination Consent and Release Templates have been developed in accordance with HIPAA guidelines as a guide for local agencies that do not have their own consent and release forms. The consent and release of information is between the patient and the local health agency therefore, the logo for the local health agency should appear on the form, in the upper left hand corner.

- Patient Information:
  The patient or a person who has the authority to act on behalf of the patient must fill out the patient information box. (i.e., Parent/Guardian). All information in this box must be filled out.

- Specialty Clinic Consent/HCP Care Coordination Consent:
  The patient or their representative must initial Yes, they consent, or No, they do not consent.

- Release of Information:
  Include the person or the class of persons authorized to make the disclosures and the person or class of persons to receive the disclosed information.

- Communication with health providers:
  The patient or person who has authority to act on behalf of the patient must provide the name of the patient's primary health care provider(s).

- Information to be released:
  A specific description of the information to be released and range of dates is required for the information to be disclosed. (Specifically indicate the release of records relating to drug or alcohol abuse, HIV status, genetic testing or mental health records. A separate authorization form is required for release of psychotherapy notes.)

- Patient/Authorized Representative Authorization:
  You must keep numbers 1 through 5 in this section. They are key components to keeping the release within the guidelines set out by HIPAA. Under the signature and date, the Patient or Authorized Representative prints their name and states their relationship or authority to act on the behalf of the patient.

  Once the local health agency has received the signed release from the patient or their representative, provide the patient with a copy and check the box indicating such.

- Family Copy of Consent
  The family should receive a copy of the signed consent.

HCP Care Coordination Interventions

HCP Care Coordination interventions are based on the core strategies of "Referrals, Education, and Services" that will address a family's goals to resolve their unmet needs. Listed below each intervention are examples of the strategies and activities that that are considered important in following through with the intervention.

REFERRALS:

Facilitate access to usual source of care

1. Discuss with family usual utilization of health care resources/ ED/Urgent Care
2. Discuss with family health beliefs
3. Identify family health concerns or questions
4. Identify family health priorities
5. Identify strategies for family to use a usual source of care and/or primary care provider other than the ER
6. Utilize Motivational Interviewing concepts for behavior change

Facilitate access to consistent primary care provider

1. Identify and facilitate source of payment
2. Provide provider name and contact information to family
3. Assist as needed in making appointment with consistent PCP
4. Assist in identifying family questions for appointment
5. Support family access to a primary care provider (e.g. transportation, child care, interpreter services), transportation and child care as needed
6. Accompany family to appointment as needed
7. Follow up with family regarding recommendations from PCP

Facilitate access to specialty care

1. Identify family health concerns, symptoms analysis (e.g. onset, duration of symptoms, alleviating and aggravating factors).
2. Consult with PCP regarding questions to be addressed by specialty provider
3. Consult with Specialty provider/PCP as appropriate regarding needed tests prior to and after appointment and needed assistance w/ care coordination.
4. Support family access to specialty care appointment with interpreter services, transportation and child care as needed.
5. Assist in understanding of needed follow up medications, treatments, referrals, and appointments.

Facilitate referrals to needed resources

1. Connect with basic services (housing, food, utilities, transportation, and clothing).
2. Connect with child/youth health care services (vision, dental, immunizations, nutrition, education, safety, durable medical equipment, therapy, tests, procedures, etc).
3. Connect with family health services (prenatal care, family planning).
4. Connect with developmental services (screening, assessment, IFSP, IEP, 504, early intervention services, early intervention therapy, and management).
5. Connect with mental health services for child.
6. Connect with mental health services for family member
7. Connect with family support services (parent to parent, respite, parent education)

EDUCATION:

Facilitate access to Early Intervention services

1. Discuss early intervention services and service coordination vs. care coordination and need to maintain communication with primary care provider
2. Ensure that primary care provider submits referral Early Intervention Colorado
3. Provide guidance and support in health information and resources during Child Find evaluation and IFSP development and review.
4. Follow up with family regarding access to therapy services and coordination with family schedule and concerns for child

Facilitate identification of and utilization of "Medical Home Team"

1. Identify current health care providers and contact information
2. Discuss how each member of medical home team is assisting family and child
3. Identify any potential team members who are needed based on family questions and unmet needs
4. Assist family in accessing needed health care team members/providers
5. Provide family with listing of medical home team members
6. Review with family how medical home team is working for them
7. Discuss strategies to improve communication among team members as needed

Facilitate development of self advocacy/efficacy skills

1. Assist family in identifying formal and informal support systems
2. Assist family in identifying their medical home team
3. Assist family in identifying unmet needs and areas of strength
4. Provide guidance in the family's development of their goals to meet their needs.
5. Guide family in clarify activities to meet goals and supports to assist in carrying out activities
6. Support family decision making strategies to meet needs
7. Discuss with family transfer of learned skills to new situations

Facilitate appropriate health care utilization problem solving and decision making

1. Consult with family to identify family cultural and health beliefs
2. Identify situations family has utilized strengths in problem solving and decision making
3. Review recommendations from primary care provider on when to call for:
    a. Well child care appointment
    b. Acute care visit
    c. Weekend and after hours concerns
    d. Urgent or emergency concerns
4. Identify specific situations requiring medical care for child and steps to obtain most appropriate health care.
5. Discuss with family their decisions to access health care resources for urgent care or emergency care and alternatives if appropriate.

Support discharge from HCP Care Coordination

1. Review family goals and accomplishment
2. Support family strengths, relationships, and skills to advocate on behalf of their child/youth
3. Discuss strategies used to accomplish goals in the past that were successful
4. Discuss formal and informal support systems
5. Review medical home team members and when to contact them
6. Review and leave family written copy of community services, support groups, and other local agencies available for support
7. Discuss availability of accessing care coordination services after discharge

SERVICES:

Facilitate access to insurance when needed

1. Determine eligibility for EPSDT CHP +, SSI, waivers or other sources of payment for health care needs.
2. Assist families in application
3. Follow up with family as to application outcome and, if needed, appeal process

Facilitate access to needed services

1. Determine appropriate health care provider (RN, SW, OT/PT, SLP, Nutrition or other providers) based on child/youth's unmet needs.
2. Assist family in identifying insurance benefit for service or alternative sources of payment for service
3. Assist family in accessing needed services
4. Follow up with family to evaluate whether or not unmet needs had been resolved

Facilitate Access to TBI Purchased Services

1. Determine if a pay source other than the TBI Trust Fund is available for the requested service
2. Assure that requested service is an approved service
3. Obtain a "Letter of Necessity" if required
4. Complete the "Computer Checklist" if purchase request is for a computer or software
5. Complete the "Request for Purchased Services" form and fax to Denver Options with required back-up documentation
6. Complete a "Request for Provider Application" if needed and fax to Denver Options
7. Follow-up with family to assure service is received and satisfactory

Facilitate Health Care Team Care Conference and Individual Health Care Plan

1. Identify health care team members and contact information
2. Identify date, time, and location for care conference
3. Identify family/youth concerns, questions, to be answered by care conference.
4. Share family concerns and questions with team members
5. Consult with family/youth for who they wish to facilitate care conference and notify them.
6. Hold care conference, and support family/youth if they choose to facilitate care conference
7. Assist the family in documenting comments of the care conference that can be used to develop the care coordination plan
8. Share care plan with all health care team members.
9. Follow up with family/youth regarding their experience and satisfaction with the care conference.

HCP Care Coordination Definitions

Definitions Used in the HCP Care Coordination Assessment and Plan Guide

BMI;	basal metabolic index
CCB:	community center board
CCAP:	Colorado Child Care Assistance Program
CDAS:	Consumer-Directed Attendant Care Services
CHP+:	Child Health Plan Plus (State Children's Insurance Program – CHIP)
DME:	durable medical equipment
DNR:	do not resuscitate
ER:	emergency room
ED:	emergency department
HCP:	Health Care Program for Children with Special Needs
Ht:	height
HS:	high school
IEP:	Individual Education Plan
IFSP:	Individual Family Service Plan
LEAP:	Low-income Energy Assistance Program
MD:	medical doctor
NP:	nurse practitioner
O2:	oxygen
PA:	physician assistant
PCP:	primary care provider
PK:	preschool /kindergarten
SES:	social economic status
TB:	tuberculosis
TBI:	Traumatic Brain Injury Program
SSDI:	Social security Disability Insurance
STD:	sexually transmitted disease
TANF:	temporary assistance for needy families
TCH:	The Children's Hospital
UTD:	up to date
WCC:	well child care
WIC:	Women's, Infant's and Children's nutrition program
Wt:	weight

HCP SPECIALTY CLINIC COORDINATION

Request for Services for Specialty Clinics may come from the PCP, family, HCP Care Coordinator, and or a community agency. The responsibilities of clinic coordination are:

1. Complete the HCP Specialty Clinic Medical History with the PCP
    - Child/youth's diagnosis and/or symptoms to be evaluated
    - Determining the PCP questions to be answered by the pediatric specialist
    - Identifying the child's current health status, medications, and response to any treatments
    - Identifying tests or procedures done and their results
2. Contact with the family and complete the **HCP Intake Interview, if not already completed.**
    - IF HCP Care Coordination is NOT needed, sending the family the Family Information Questionnaire to the family for completion.
    - IF HCP Care Coordination IS needed, sending the Request for HCP Services to the appropriate HCP Care Coordinator
3. Consult as needed with the pediatric specialist to determine:
    - Urgency of the appointment
    - Scheduling priorities
    - Additional tests or procedures needed prior to the specialty clinic appointment
4. Consult with the PCP regarding:
    - Needed tests and procedures prior to the specialty clinic
5. Schedule the patient appointment
    - Send appointment reminders or request care coordinator to confirm with family
6. Attend the specialty clinic to provide staff support as requested by the specialty provider
    - Verify patient contact and insurance information
    - Initiate the ***HCP Specialty Clinic Visit Record*** re: current health status and medications
    - Obtain vital signs, height and weight measurements
    - Assure the families understanding to the recommendations and follow up needed
7. Follow up with the PCP regarding:
    - Specialty clinic recommendations for follow up tests and procedures
    - Medications changes
    - Specialty clinic follow up appointments
8. Follow up with the HCP Care Coordinator (if available) regarding:
    - Clinic recommendations and any needed follow up with the family
9. Follow-up with the family, PCP, or HCP Care Coordinator re: follow up appointments.

See the ***HCP Specialty Clinic Policy and Guidelines*** for more information.

APPENDIX

Appendix A-1:	HCP Intake Interview (English)	REVISED
Appendix B:	Request of HCP Services	REVISED
Appendix C-1	HCP Family Interview Questionnaire (English)	REVISED
Appendix D-1	HCP Care Coordination Assessment and Planning Guide LONG	
Appendix D-2	HCP Care Coordination Assessment and Planning Guide SHORT	
Appendix E	HCP Care Coordination Assessment and Plan Outline	REVISED
Appendix F	HCP Care Coordination Consent	NEW

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http://www.cdphe.state.co.us/ps/mch/index.html

Colorado Department of Public Health and Environment – Children with Special Health Care Needs Title V
http://www.cdphe.state.co.us/ps/hcp/index.html

Colorado Department of Public Health and Environment – Medical Home Initiative
http://coloradomedicalhome.com/cmhi.html

Colorado Federation of Families for Children's Mental Health
http://www.coloradofederation.org/

Early Intervention Colorado
http://www.eicolorado.org

Family Voices – Colorado
http://www.familyvoicesco.org/

Health Care Policy and Finance – EPSDT Program (Medicaid)
http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1218622604254

Health Resources and Services Administration - EPSDT
http://www.hrsa.gov/epsdt/

Health Resources and Services Administration - Maternal and Child Health Bureau
http://mchb.hrsa.gov/

OTHER RESOURCES

"Case Management for Mothers and Children," National Maternal and Child Health Resource Center, Association of Maternal and Child Health Programs, Annual Meeting, May 22, 1988.

"Children with Special Health Care Needs in Managed Care Organizations: Definitions and Identification Family Participation, Capitation and Risk Adjustment, Quality of Care," Division of Services for Children with Special Needs, Maternal and Child Health Bureau, December, 1996.

Colorado Department of Public Health and Environment, Women's Health Section, Colorado Department of Health Care Policy and Financing, Health Plans and Medical Services, *Prenatal Plus Provider Manual*, 2/16/96.

Eden, Joan, M.S.P.H., R.D., "Care Coordination", 1997.

"Enhanced Care for High Risk Individuals," Maryland contract between CSHCN and Medicaid, Attachment 1.E, 1/24/96.

Hamilton, Haynes, Todd, Gomez, Horne, Feldman, Johnson, Knaack, Slay, Care Coordination Training and *Resource Compendium*, Spring, 1998.

Hays, Beverly J., "Nursing Intensity as a Predictor of Resource Consumption in Public Health Nursing," *Nursing Research*, Mar/April, 1995.

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Renken, Catherine A., RN, MPH, Director and Judith Wickman, RN, B.S.N., Nurse Consultant, "CaCoon--CAre COordinatiON," *CaCoon Program Manual*

"Skilled Professional Assessment, Care Planning and Coordination Activities (Enhanced)," Seattle/King County Cooperative Agreement with Washington State Social Services, SSDI-Ciss-news: *PIC Alert*, July, 1998.

"Standards for Social Work", *National Association of Social Workers (NASW)*, June 1992.

Trierweiler, Karen, C.N.M., M.S., Jane Cotler, R.N., M.S., C.S.N., Jan McNally, R.N., M.S., *An Introduction to Home Visitation,* Colorado Department of Public Health and Environment, March, 1996.

University of Kentucky College of Nursing, *National Standards of Nursing Practice for Early Intervention Services*, July 1993.

HCP INTAKE INTERVIEW
Agency Information

A
Agency
Logo

Intake Date: _____ **HCP Staff:** _____

Child/Youth's Name:		***Birthdate: mm/dd/yyyy***		***Age: yr/mo***	

Family Member Providing Information: ***Relationship:***

Parent/s Name (if different): ***Phone:***

What questions or concerns do you have about your child?

1. What is your child or youth's usual source of sick and well care? *(Check only one)*

- ☐ *PCP*
- ☐ *Clinic*
- ☐ *Urgent Care*
- ☐ *Emergency Room*
- ☐ *None*
- ☐ *No Response*

2. Does your child or youth have a consistent primary care provider (physician, nurse practitioner, physician assistant)?

- ❑ *Yes*
- ❑ *No*
- ❑ *No Response*

3. Does your child or youth have health insurance?

- ❑ *Yes*
- ❑ *No*
- ❑ *No Response*

4. Does your child or youth require medical specialty care services?

- ❑ *Yes, Do you need any assistance regarding medical specialty care services? _____ Yes _____ No _____ No Response*
- ❑ *No*
- ❑ *No Response*

5. Does your child or youth or anyone in your family use any community family support services or resources?

- ❑ *Yes,* ***Circle services currently being USED below***
- ❑ *No*
- ❑ *No Response*

6. Does your child or youth or anyone in your family need assistance accessing community family support services or resources?

- ❑ *Yes,* ***Circle services NEEDED below***
- ❑ *No*
- ❑ *No Response*

Circle services being used or needed

Early Intervention Services	Using	Need	WIC	Using	Need
EPSDT Outreach	Using	Need	Social Services	Using	Need
School nurse	Using	Need	Mental Health	Using	Need
NFP	Using	Need	Other (specify)	Using	Need

HCP Services Requested
Check all that apply

- ☐ Referrals provided to (Specify):
  - ____ PCP ____ Specialist
  - ____ EI Colorado ____ EPSDT
  - ____ School nurse ____ NFP
  - ____ Other: _____ (specify)
- ☐ HCP Care Coordination Level 2 or 3
- ☐ HCP TBI Care Coordination
- ☐ HCP Specialty Clinic

Reason HCP Services Not Requested
Check only one

- ☐ Family does not need care coordination
- ☐ Adequate care coordination from other agency
  - ____ PCP ____ Specialist
  - ____ EI Colorado ____ EPSDT
  - ____ School nurse ____ NFP
  - ____ Other: _____ (specify)
- ☐ Family will provide care coordination

Care Coordinator Assigned: _____ Date Assigned: _____

Request for HCP Services

B - 1
Local
Logo

_____Health Department
Address: _____
Phone: _____
Fax: _____

DATE OF REQUEST:

Provider/Agency Name**:**			
Address:		**Zip:**	
Contact Person:		**Title:**	
Contact Phone:	**Fax:**	**Contact e-mail:**	
Report Back Due Date: _____ **By: phone call:** _____**; fax back:** _____**; e-mail report** _____			
Child/Youth Name:		***BD***	***Age***	***Gender: M F***
Person to Contact:		***Relationship***	
Mailing address:		**Zip:**	
Home Phone:	**Work:**	**Cell:**	
Home address (if different)	**Zip:**	**e-mail:**	
Is family/youth aware of request? Yes No			
Concern/s to be addressed:			
Additional Family Information (additional information on the back)			

HCP Services Requested:

- ☐ HCP Care Coordination
  - ☐ Care Coordination assessment. plan, and follow up for child/youth health and/or developmental needs
  - ☐ Care Coordination assessment, plan, and follow up for family health needs
  - ☐ Assistance connecting to or coordinating health services or specialty care: _____
  - ☐ Health education/anticipatory guidance: ___ _____
  - ☐ Assistance connecting to community services: _____
  - ☐ Other _____
- ☐ HCP Specialty Clinic: _____ Neurology; ____ Rehab; ____ Ortho; ____ Cardiology;
- ☐ Diagnostic and Evaluation Clinic (D & E Clinic) _____

REFERRAL FORWARDED TO: _____

REPORT BACK: Summary of HCP Care Coordinator Visit:

- ☐ Referrals, Education and Services provided:

  _____

- ☐ Unable to contact: _____

HCP Care Coordinator Follow Up Plans:

- ❑ Will continue to follow. I will provide you with updates in _____ months.
- ❑ No further contact needed or planned
- ❑ No further contact wanted by the family

If you have any questions about the HCP Care Coordination services for this child/youth please do not hesitate to contact me at the phone number below.

Name of HCP Care Coordinator, Title/Credentials: _____
Address _____
Phone number e-mail _____

B – 2 Agency Logo

Request for HCP Services

Agency Name: _____
Address: _____
Phone: _____
Fax: _____

DATE OF REQUEST:

Primary Care Provider**:**			
Address:		**Zip:**	
Contact Person:		**Title:**	
Contact Phone:	**Fax:**	**Contact e-mail:**	
Report Back Due Date: _____ **Phone call:** _____; **Fax back:** _____; **e-mail report** _____			

TO: HCP Office:			
Contact Phone:	**Fax:**	**Contact e-mail:**	
Address:		**Zip:**	

Child/Youth Name:	***BD***	***Age***	***Gender: M F***
Person to Contact:		***Relationship***	
Mailing address:		**Zip:**	
Home Phone:	**Work:**	**Cell:**	
Home address (if different)	**Zip:**	**e-mail:**	
Is family/youth aware of request? Yes No			
Concern/s to be addressed:			
Additional Family Information (additional information on the back)			

HCP Services Requested:

- ☐ HCP Care Coordination
  - ☐ Care Coordination assessment. plan, and follow up for child/youth health and/or developmental needs
  - ☐ Care Coordination assessment, plan, and follow up for family health needs
  - ☐ Assistance connecting to or coordinating health services or specialty care: _____
  - ☐ Health education/anticipatory guidance: ___ _____
  - ☐ Assistance connecting to community services: _____
  - ☐ Other _____
- ☐ HCP Specialty Clinic: _____ Neurology; ____ Rehab; ____ Ortho; ____ Cardiology (locations at www.hcpcolorado.org)
- ☐ Diagnostic and Evaluation Clinic (D & E Clinic) _____(locations at www.hcpcolorado.org)

REFERRAL FORWARDED TO: _____HCP Care Coordinator

REPORT BACK: Summary of HCP Care Coordinator Visit:

- ☐ Referrals, Education and Services provided:

  _____

- ☐ Unable to contact: _____

HCP Care Coordinator Follow Up Plan:

- ❑ Will continue to follow. I will provide you with updates in _____ months.
- ❑ No further contact needed or planned
- ❑ No further contact wanted by the family

If you have any questions about the HCP Care Coordination services for this child/youth please do not hesitate to contact me at the phone number below.

Name of HCP Care Coordinator, Title/Credentials: _____
Address _____
Phone number e-mail _____

Health Care Program for children with Special Needs
Together we'll find the way.

C-1
Agency Logo

HCP Family Information Questionnaire

_____Health Department
Address: _____
Phone: _____

DATE:

Child's Name:			
	M F	***Birth date***	***Age***

Race / Ethnicity	***Ethnicity***
☐ Alaska Native ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian/White ☐ Other _____ ☐ Pacific Islander	☐ Hispanic ☐ Non-Hispanic

Parent / Guardian / Caregiver Information

Number of Adults in the home:			***Number of Children in the home:***	
Parents	***Birth date***	***Age***	***Place of Employment:***	***Phone Number***
Mother's name:				
Father's name:				

Mailing address: Zip: Parent's e-mail:

Home address (if different) Zip:	Home phone: Cell phone(s):
Family Emergency Contact with phone number:	Language spoken/Read: _____ Non English Speaking Only: ___
Foster Care/ Guardian Provider name:	Foster Care/Guardian Phone Number:
Foster Care / Guardian Mailing Address	
Case Worker Name:	Phone Number:

Household / Family Members (not including parent(s) listed above):	**M F**	**Age**	**Relationship to Child**	**Contact Phone Numbers**

School District		**Contact name:**	**Number:**

Insurance information: (Please check all that apply)

___ ***Private Insurance (Company name)_____Number:*** _____
___ ***Medicaid; _____ CHP+; ____ SSI/SSDI ; _____No Insurance; _____ Number:*** _____

FOR HCP SPECIALTY CLINICS or IF INTERSTED IN OTHER POSSIBLE ELIGIBLE COMMUNITY SERVICES

To qualify for the HCP sliding scale clinic fee or if interested in other eligible services please estimate your family's household income: Annual Income: _____ OR Monthly Income _____ All HCP families will qualify for an adjusted Specialty Clinic fee scale.

Family Member Providing Information: _____ Relationship: _____
HCP Coordinator or Family Care Coordinator: _____Date :_____

Health Care Program for children with Special Needs
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HCP Care Coordination Assessment and Planning Guide

D-1

Child/Youth's Name: _____ Date of Birth: _____ Age: _____ Gender: M ___ F ___

Parent questions and concerns:

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	**Assessed**	**Unmet Need**	**Not Applicable**	**Pending**	*Assessment, Family Goals, Plan of Care, Interventions* **NOTES**
CHILD/YOUTH HEALTH					
Access to Health Care:					
• *Usual source of care other than ER*					
• *Consistent MD, NP, or PA for WCC*					
• *Access to specialist*					
Past Medical History:					
• *Complex or No diagnosis*: Rec. Rev..					
• *High risk pregnancy*					
• Birth history: *Premie or Birth Defect*					
• *Immunization UTD*					
• Allergies					
• *ER Visits, Hospitalizations*					
• Accident history					
Current Health Status:					
• Oral health exams/dentist					
• Vision test/provider					
• Hearing test/ audiologist					
• Tests and procedures needed					
Nutrition and Growth:					
• Nutritionist/dietician					
• Feedings: tube feeding or special formula					
• Wt to Ht ration/ BMI explained to family					
• Mealtime schedule and routines					
Medications:					
• Prescribed, OTC or alternative meds					
Treatments/Rehab Needed:					
• Therapists: OT, PT, SLP, SI,					
• Cognitive Therapist					
Equipment:					
• *DME*: O2, vent. wheel chair					
• G-tube, feeding pump					
• Medical supply/seating provider					
• Adaptive equipment					
Personal Safety:					
• Home and community safety					
• *Emergency plan for medical needs*					
• Car seat, crib/bed safety, helmets					
• Sexual abuse/prevention					

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	**Assessed**	**Unmet Need**	**Not Applicable**	**Pending**	*Assessment, Family Goals, Plan of Care, Interventions* NOTES
CHILD/YOUTH DEVELOPMENT					
Screening/Assessments:					
• *Developmental screening*: PCP or other					
• Child Find evaluation					
• Evaluations: motor, speech, social-emotional					
• Neuropsychological screen/evaluation					
• *Developmental delay/disability*					
Cognitive Functioning:					
• Learning and memory					
• Problem solving and decision making					
• Math and calculation					
• Organizational skills, multitasking					
• Handling change and transitions					
Self care/Daily routines:					
• Caregiver and self regulation					
• *Sleep/wake routines and activity*					
• Dressing, self care					
• Hygiene and bathing					
• Play: active and quiet play					
• TV, computer and screen time					
Early Intervention Services (0-3 Years):					
• **Early Intervention Colorado**					
• Service coordinator					
• IFSP completed					
Education (PK – 12) (PS through HS):					
• IEP					
• 504 Plan					
• Special Ed. eligibility, services, grievance					
Transition:					
• CCB for supported living services					
• *Transition plan to adult provider*					
• College entry assistance					
• Vocational rehab					
• Employment options					
• Guardianship					
• Health literacy					
Additional Notes:					

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	**Assessed**	**Unmet Need**	**Not Applicable**	**Pending**	*Assessment, Family Goals, Plan of Care, Interventions* NOTES
FAMILY STATUS					
Family Health:					
• *Family primary care source*					
• Family specialty care					
• Prenatal care					
• Family planning					
• Cultural health beliefs					
Family Functioning/Advocacy Skills:					
• *Single parent*					
• *Teen parent/s*					
• *Foster care, grandparent care*					
• *Planning, prioritizing*					
• *Decision making, coping strategies*					
• *Geographic isolation*					
• Family communication and relationships					
Parent Child Relationships					
• Parenting knowledge and skills.					
• Discipline strategies					
• Child abuse concerns					
Support Systems:					
• *Extended family support system*					
• *Utilization of resources*					
• Child care and respite					
• Faith based resources					
• Cultural supports. Interpreter					
• *Parent and grief supports*					
• Parent leadership interest					
Education:					
• *Parent education (< high school)*					
• *Language barrier*					
• Health Literacy/ Learning style					
PSYCHOSOCIAL STATUS					
Child emotional-mental health:					
• Infant mental/emotional health					
• *Mental health diagnosis*					
• *Depression*					
• *Mental health evaluation/provider*					
• Adjustment and coping behaviors to diagnosis					
• Relationships with family					
• Relationships with peers					
Family mental health:					
• *Mental/emotional health* diagnosis					
• *Mental health evaluation/provider*					
• *Depression, post-partum depression*					
• *Substance abuse*					
• *Past abuse or neglect*					

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	**Assessed**	**Unmet Need**	**Not Applicable**	**Pending**	*Assessment, Family Goals, Plan of Care, Interventions* NOTES
BASIC NEEDS					
Home Environment:					
• Housing and utilities, *homelessness*					
• Food					
• Clothing					
• *Transportation*					
• Home safety, repairs/modifications needed					
Financial Status:					
• *Low SES, below 200% poverty*					
• Employment or workman's co					
• Child support (received/paid)					
• Large debt					
Insurance:					
• Medicaid, SSDI, CHP +, waivers					
• Adequate private insurance					
• Presumptive eligibility					
• *No insurance*					
• Insurance grievance or bill reconciliation					
COMMUNITY SUPPORT SERVICES					
Community Supports Available:					
• *Appropriate local supports available*					
• Philanthropic or charity funding sources: TCH, Rotary, Shiners, etc.					
Public Health:					
• HCP/TBI					
• WIC					
• Family Planning					
• Prenatal + or Nurse Family Partnership					
• TB, HIV, STD program, wellness programs.					
Human Services:					
• Food stamps					
• CDAS, LEAP, CCAP, TANF					
Legal Issues:					
• Juvenile detention					
• Immigration					
• DNR					
• Legal aid					
Home Health Services:					
• Home care services, readiness for home care					
• Long term, extended or acute care, hospice.					
• Parent certification as CNA					
• Home care allowance					
FOLLOW UP PLAN:					*Next Visit:*

HCP Care Coordinator: _____ **Date:** _____

Health Care Program for children with Special Needs
Together we'll find the way.

HCP Care Coordination Assessment and Planning Guide

D-2

Child/Youth's Name: _____ Date of Birth: _____ Age: _____ Gender: M ___ F ___

Parent questions and concerns:

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	**Assessed**	**Unmet Need**	**Not Applicable**	**Pending**	*Assessment, Family Goals, Plan of Care, Interventions* NOTES:
CHILD/YOUTH HEALTH					
Access to Health Care: *Usual source of care other than ER; Consistent MD, NP, or PA for WCC; Access to specialist*					
Past Medical History: *Complex or No diagnosis*: **Rec. Rev.;** High risk pregnancy; Birth history: Premie or Birth Defect; *Immunization UTD;* Allergies; *ER Visits, Hospitalizations;* Accident history					
Current Health Status: Oral health exams/dentist; Vision test/provider; Hearing test/ audiologist; Tests and procedures needed					
Nutrition and Growth: Nutritionist/dietician; Feedings: tube feeding or special formula; Wt to ht ration/ BMI explained to family; Mealtime schedule and routines					
Medications: Prescribed, OTC or alternative meds					
Treatments/Rehab Needed: Therapists: OT, PT, SLP, SI, ; Cognitive Therapist					
Equipment: *DME:* O2, vent. wheel chair; G-tube, feeding pump; Medical supply/seating provider; Adaptive equipment					
Personal Safety: Home and community safety; *Emergency plan for medical needs;* Car seat, crib/bed safety, helmets; Sexual abuse/prevention					
CHILD/YOUTH DEVELOPMENT					
Screening/Assessment: *Developmental screening*: PCP or other; Child Find; evaluation; Evaluations: motor, speech, social-emotional; Neuro-psychological screen/evaluation; *Developmental delay/disability*					
Cognitive Functioning: Learning and memory; Problem solving and decision making; Math and calculation; Organizational skills, multitasking Handling change and transitions					
Self care/Daily routines: Caregiver and self regulation; *Sleep/wake routines and activity;* Dressing, self care; Hygiene and bathing Play: active and quiet play; TV, computer and screen time					
Early Intervention Services (0-3 Years): **Early Intervention Colorado;** Service coordinator ; IFSP completed					
Education (PK – 12) (Preschool through HS): IEP; 504 Plan; Special Ed. eligibility, services, grievance					
Transition: CCB for supported living services; *Transition plan to adult provider;* College entry assistance; Vocational rehab; Employment options; Guardianship; Health literacy					
Additional Comments:					

CHIRP ENTRY GUIDE ***Strengths and Unmet Needs*** *Assessment Priorities & Risk Factors*	**Assessed**	**Unmet Need**	**Not Applicable**	**Pending**	*Assessment, Family Goals, Plan of Care, Interventions* NOTES
FAMILY STATUS					
Family Health: *Family primary care source;* Family specialty care Prenatal care; Family planning; Cultural health beliefs					
Family Functioning/Advocacy Skills: *Single parent; Teen parent/s; Foster care; Grandparent care; Planning & prioritizing: decision making, coping strategies;* Family communication and relationships					
Parent-child relationships: Parent knowledge & skills; Discipline strategies; Child abuse concerns					
Support Systems: Extended family support system; *Geographic isolation; utilization of resources*; Child care; Respite; Faith based resources; Cultural supports. Interpreter; *Parent and grief supports;* Parent leadership interest					
Education: *Parent education (< high school); Language barrier;* Health Literacy/ Learning style					
PSYCHOSOCIAL STATUS					
Child emotional-mental health: *Infant mental/emotional health; Mental health diagnosis Depression;* Evaluation/provider*;* Adjustment and coping behaviors to diagnosis; Relationships with family; Relationships with peers					
Family mental health: *Mental/emotional health diagnosis;* Mental health valuation and provider*; Depression, post-partum depression; Substance abuse; Past abuse or neglect*					
BASIC NEEDS					
Home Environment: Housing and utilities, homelessness; Food; Clothing; transportation, Home safety, repairs/modifications needed					
Financial Status: *Low SES, below 200% poverty*; Employment or workman's comp; Child support (received/paid); Large debt					
Insurance: Medicaid, SSI, CHP +, waivers; Adequate private insurance; Presumptive eligibility; No insurance; Insurance grievance or bill reconciliation					
COMMUNITY SUPPORT SERVICES					
Community Supports Available: *Appropriate local supports available;* Philanthropic or charity funding sources: TCH, Rotary, Shiners, etc					
Public Health: HCP/TBI; WIC; Family Planning; Prenatal + or Nurse Family Partnership; TB, HIV, STD program, wellness programs.					
Human Services: Food stamps; CDAS, LEAP, CCAP, TANF					
Legal Issues: Juvenile detention; Immigration; DNR; Legal aid					
Home Health Services Home care services, readiness for home care; Long term, extended or acute care, hospice; Parent certification as CNA; Home care allowance					
FOLLOW UP PLAN: *Next Visit:*					

HCP Care Coordinator: _____ **Date:** _____

HCP CARE COORDINATOR INITIAL ASSESSMENT and PLAN
OUTLINE

E

Date of Visit:

Name of Child/Youth:
Birthday: **Age**: **CHIRP Number**:
Care Coordinators Name:
Date of Visit:
Family Members Interviewed:

Referral Source

FAMILY CONCERNS/QUESTIONS:

FAMILY/CHILD ACTIVITIES TOGETHER:

ASSESSMENT (subjective and objective information)

Child Health:

Child Development:

Family Status:

Psychosocial Status:

Basic Needs:

Community Support Services:

ASSESSMENT SUMMARY: **Strengths and unmet needs**

FAMILY GOALS: **Family goals identified with the family**

INTERVENTIONS: **Referrals, education, services to be implemented by family & care coordinator**

FOLLOW UP PLANS: **Next care coordination contact with family**

HCP Care Coordinator *Date*
Title

H
<Regional Office Logo>

Health Care Program for children with Special Needs
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HCP Care Coordination Consent and Release

Patient Information	**Patient Name** _____ (Last / First / MI) **Birth Date** _____ **Phone #** _____ **Address** _____ (Street / City / State / Zip Code)
HCP Care Coordination Consent	I hereby ***consent to the provision of care coordination*** and other requested health services including but not exclusive of: health and family history assessments, resource identification and referral, and consultation with other community agencies identified below. I authorize and request the health professionals of <Regional Office> take such actions, as are necessary and desirable in the exercise of professional judgment when providing care coordination and other requested health services for my family. Please Initial: _____ Yes, I consent to services / _____ No, I do not consent to services
Release of Information	I authorize the <Regional Office> Health Care Program for Children with Special Needs, to release and exchange information with the following agencies for the purposes of treatment and care coordination: _____ _____ _____ _____
Communication with Health Providers	I further authorize <Regional Office> Health Care Program for Children with Special Needs, to communicate and correspond with the above named child's (patient) primary care provider, other health providers indicated below, and/or their office staff for the purposes of treatment and care coordination. This includes telephone, secure email, fax, or written correspondence. Name of primary care provider _____ Name of other health provider _____ Name of other health provider _____
Information to be Released	Copies of any and all health and family history assessments, chart notes, doctor's notes, any diagnosis, test results, copies of x-rays/scans, lab results, care coordination assessment and follow-up notes, specialty clinic dictations, and any screening results in your possession. For the time period of: _____/_____/_____ to _____/_____/_____
Patient/Authorized Representative Authorization	I understand that: (1) My signature on this form is strictly voluntary. (2) I may revoke this authorization at any time in writing, and if I do it will not have any effect on any actions taken prior to receiving the revocation. (3) If the requester or receiver is not a health plan or health care provider, the released information may be disclosed by the recipient and may no longer be protected by federal privacy regulations. (4) If I do not sign this form, my health care, the payment for my health care or my ability to enroll for benefits will not be affected. (5) I may inspect or obtain a copy of the health information that I am being asked to disclose. Expiration: Without my express revocation, this consent will automatically expire upon termination of services with <Regional Office> Health Care Program for Children with Special Needs, unless otherwise specified. Specified expiration date (optional) _____ **Signature** _____ **Date** _____ Printed Name: _____ Relationship to Patient/Authority to Act: _____

OFFICE USE:
☐ COPY TO PATIENT OR PERSONAL REPRESENTATIVE